MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04674

Reg. Diat. No. 22

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Laurel Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Laurel Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Ernest Altvater

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Katie C. Altvater
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 12, 1865

8. AGE: Years	Months	Days	If less than one day
81	8	11	____ hrs. ____ min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Produce Dealer
11. Industry or business: Retired
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Germany
16. Informant: Mrs. Henry Seitz
Address: 5-34 Harley Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-26-47 (month) (day) (year).
Cemetery or crematory: Meadowridge Memorial
Location: Elkridge Md.
18. Funeral director: George L. Schwab
Address: 2101 Frederick Ave.
19. June 23 1947 (Date rec'd by registrar) Elana Kastuk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23, 1947, at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11 1947 to June 23 1947 and that I last saw h. alive on June 6 1947

Immediate cause of death	DURATION
Acute myocardial insufficiency	1 day
Due to Chronic Myocarditis	6 mo
Due to Hypertension & general arteriosclerosis	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: John A. Stephens M.D.
M. D. or other
Address: Laurel, Maryland Date signed 6/23/47

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04675

CERTIFICATE OF DEATH

Reg. Dist. No. 23

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A A County
City or town Curtis Creek Curtis Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel County
City or town Curtis Creek Curtis Bay R.D. 26
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Banta

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of ~~husband~~ or wife Carmelia R Banta
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 25 - 1865

8. AGE: Years	Months	Days	If less than one day
82			..... hrs. ..... min.

9. Birthplace New Dover N. J.
(Town, county, and state)
10. Usual occupation machinest
11. Industry or business Self
MOTHER FATHER 12. Name George Banta
13. Birthplace New Jersey
MOTHER 14. Maiden name Martha Harrell
15. Birthplace Pa
16. Informant Mr George Hutchings
Address Curtis Creek Curtis Bay-26
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6-47. (month) (day) (year)
Cemetery or crematory Holy Cross Cemetery
Location Gr. Ritchie Highway
18. Funeral director Milton Schilling
Address 3914 Hanover St
19. June 5 1947 (Date rec'd by registrar) Ida M. Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th 1947, at 1.P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2 1946, to June 4 1947, and that I last saw him alive on June 4 1947

Immediate cause of death	DURATION
Heart failure	
due to Arterio sclerosis	
Due to Carcinoma of pancreas	
Due to	
Other conditions Bilateral inguinal hernia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M. D. or other
Address 203 Patapsco Ave Date signed 6/5/47

04676

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: ANNE ARUNDEL Co.
City or town: GREEN HAVEN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: ANNE ARUNDEL
City or town: GREEN HAVEN
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 TH ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY G. BOSZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED

6.(b) Name of husband or wife: ANNIE E. BOSZ (EVERD)
6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): JUNE 23 1868

8. AGE:

Years	Months	Days	If less than one day
78			...hrs. ...min.

9. Birthplace: BALTIMORE, MD.
(Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business

FATHER
12. Name: ADAM BOSZ
13. Birthplace: GERMANY

MOTHER
14. Maiden name: MARIE LEPPERT
15. Birthplace: GERMANY

16. Informant: MR. STEPHEN BOSZ
Address: GREEN HAVEN A.A. Co.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6 13 47 (month) (day) (year)
Cemetery or crematory: GLEN HAVEN
Location: RITCHIE HIGHWAY
18. Funeral director: JOHN F. DENNY, INC.
Address: 715 LIGHT ST.

19. 6/12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 11, 1947, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/7/47, 19..., to 6/11/47, 19...
and that I last saw him alive on 6/6/47, 19...

	DURATION
Immediate cause of death	
Coronary Thrombosis	4 Hours.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Neumeier M. D. or other
Address: Glen Burnie Md. Date signed: 6/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and complete answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Alexander

9:30 to 11:A

6:30 to 8:30 PM

04677

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

950

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Edgewater

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred: Forestville & Brantwood Rd. Woodland Beach

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No. Forestville & Brantwood Rd. Woodland Beach

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jonah Boyle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Wilhelmine M. Boyle

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): ~~Nov~~ October 5, 1874

8. AGE: Years	Months	Days	If less than one day
72	8	14	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Railroad

FATHER — 12. Name: James Boyle

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Susan Thackery

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Mrs. W. M. Boyle

Address: Woodland Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 1947 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md

18. Funeral director: W. C. White Co

Address: Laurel Md

19. June 21 1947 (Date rec'd by registrar) Clara Hasleft Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1947 at 11 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1947 to June 19 1947 and that I last saw him alive on May 27, 1947

Immediate cause of death	DURATION
Coronary thrombosis	
Due to: Congestive heart failure	
Due to: (Cardiac hypertrophy & dilatation)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D. M. D. or other

Address: Annapolis, Md. Date signed June 21, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

04678

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 910 Severn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Susan E. Brewer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife Thomas H. Brewer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec 26th 1871

8. AGE: Years 75 | Months 5 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Thomas Brooks
13. Birthplace Annapolis Md.
MOTHER 14. Maiden name Susan E. Brewer
15. Birthplace A A Co Md.
16. Informant Mrs John Carlson
Address Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21-1947 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor Sons
Address Annapolis Md.
19. June 21 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 3:47 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947, to June 17 1947
and that I last saw her alive on June 17 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	June 9
Due to Hypertension	2 years
Due to	
Other conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE George C Boxil M. D. or other
Address Annapolis Date signed 6-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04679

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 months, 23 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 year, 11 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mattie - Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Unknown to us 1860

8. AGE: Years	Months	Days	If less than one day
about 67	?	?	... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: Henry Brown

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Thomas

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-14-47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Ruff's

Address: Crownsville

19. 6-14-47 (Date rec'd by registrar) 19... E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 19 47 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 45 to June 7 19 47

and that I last saw her alive on June 7 19 47

Immediate cause of death	DURATION
(a) Chronic Myocarditis	Known to us since June 15, 1945
Due to:	
Due to:	
Other conditions: Senile Psychosis	Known to us since June 15, 1945

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville Md. Date signed 6-9-47

State of Md.

~~BALTIMORE CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. 65306 P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Anne Arundel

(a) ~~Baltimore City~~, Maryland

(b) Street address: Hammonds Ferry Rd.

(c) Hospital or institution: Linthicum, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 04680

(a) State Maryland (b) County

(c) City or town Baltimore - Rural
(If outside city or town limits, write RURAL and give town)

(d) Street No. Hammond Ferry Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Buhl

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Henrietta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1863

8. AGE: Years	Months	Days	If less than one day
83	8	29	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name John Buhl

13. Birthplace Germany

MOTHER

14. Maiden Name Lena Unknowned

15. Birthplace Germany

16 (a) Informant William Litsinger

(b) Address 1125 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/47 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) July 1, 1947 (Date rec'd by registrar) (b) A. H. Schuck Registrar

MEDICAL CERTIFICATION

20

20. DATE OF DEATH 6-28-47 19 , at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1947 to 6-28 1947 and that I last saw h alive on 6-28 19 47

Immediate cause of death Acute Cardiac Failure — Duration 1 day

Due to Generalized Arteriosclerosis

Due to Arterio Sclerotic Cardio Vascular Disease — Duration 7 mos

Other Conditions Prostatitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph Chamberlain M. D.

Address 614 Washington Blvd Date signed 6/30/47

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

04681

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred:
33 Hutton Place
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 Hutton Place
(If rural, give LOCATION)
2.(a) If veteran, name war: ********

3.(a) FULL NAME: Elvary Little Carey

3.(b) Social Security Number: 215-14-4459

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: ** Nason Carey
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 1914

8. AGE: Years	Months	Days	If less than one day
33			....hrs. ....min.

9. Birthplace: Annapolis Md. A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Walter Little Sr.
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Florence Galloway
15. Birthplace: Annapolis Md.

16. Informant: Mr Walter Little
Address: 51 Fleet St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/ 6/47 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. June 6, 1947 (Date rec'd by registrar) W. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1947, at 1 20 A M

21. I CERTIFY that death occurred on the date above stated, at ********** Postmortem Examination
at ********** June 4 1947

Immediate cause of death	DURATION
Due to: Fracture of Skull	
Due to: and Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 6-4-47
Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: a blunt instrument Injured at work? no

23. SIGNATURE: John N. Claffy M.D. M. D. Deputy Medical Examiner
Address: Annapolis Md. Date signed 6-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Name of cause is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04682

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 Prince Geo St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Harry L. Catlin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Rose Catlin
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 12th 1887

8. AGE: Years	Months	Days	If less than one day
60	3	19	hrs. min.

9. Birthplace A. A. Co Md.
(Town, county, and state)
10. Usual occupation Painter
11. Industry or business

FATHER
12. Name Wm E. Catlin
13. Birthplace A A Co Md

MOTHER
14. Maiden name Annie Dove
15. Birthplace A. A. Co Md

16. Informant William C. Catlin
Address 127 Prince Geo St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4th 1947 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md
18. Funeral director John M. Taylor Son
Address Annapolis Md.
19. June 4, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1947 at 12:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1947 to June 1 1947
and that I last saw h[illegible] alive on June 1 1947
Immediate cause of death

	DURATION
Coronary Thrombosis	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M.D.
M. D. or other
Address Annapolis, Md Date signed June 4, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1752

CERTIFICATE OF DEATH

04683

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 min.

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - near Jessup
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Agnes Catterton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Frank Catterton

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Apr 15. 1902

8. AGE: Years: 39 Months: Days: If less than one day: hrs. min.

9. Birthplace: Mayo (Town, county, and state)

10. Usual occupation: House work

11. Industry or business

MOTHER FATHER

12. Name: John Westley Ball

13. Birthplace: Md

14. Maiden name: Elizabeth J. Whitehead

15. Birthplace: Shady Side Md

16. Informant: Fred Ball

Address: Mayo Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15 1947 (month) (day) (year)

Cemetery or crematory: St Calvary

Location: Drum Point Md

16. Funeral director: H. C. Saunderson Son

Address: Galesville Md

19. June 13 19 47 (Date rec'd by registrar)

Your Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1947, at 6 15 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Fracture of skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of June 11, 1947

Where did injury occur? near Jessup (City or town) a. a. (County) md. (State)

Injured at home, farm, industry, public place (where?): farm

Means of injury: Crushed by water tank Injured at work? Yes

23. SIGNATURE: E. Peyton Ritchie, M.D.
M.D. or other acting M.E.

Address: Annapolis, Md. Date signed: June 11, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH 04684

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County Anne Arundel County Registration Dist. No. 21

Village or City Emergency Hospital No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME HIRAM ALVIN CUMMINGS If U. S. Veteran, specify WAR

(a) Residence: No. MAYO, MD. St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Cummings

6. DATE OF BIRTH (month, day, and year) Dec 10 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	5	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Night Watchman

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Beverly Beach

10. Date deceased last worked at this occupation (month and year) 5/47

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Mayo Md

FATHER

13. NAME William H. Cummings

14. BIRTHPLACE (city or town) (State or country) Mayo Md

MOTHER

15. MAIDEN NAME Etta May Gardner

16. BIRTHPLACE (city or town) (State or country) Talbot Co Md.

17. INFORMANT Alice E. Cummings
(Address) Mayo Md

18. BURIAL, CREMATION, OR REMOVAL
Place Burial Date 6/9, 1947

19. UNDERTAKER T. A. Hardesty & Son
(Address) Galesville Md

20. FILED June 9, 1947 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June (Month) 6 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 29th, 1947, to June 6, 1947

I last saw him alive on June 5th, 1947; death is said to have occurred on tha date stated above, at 11 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Pneumonia - Bronchial	5-27-47

Other Contributory Causes of importanca:

Tbc. - fibrosis

Name of operetion Date of

Whet test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? None Date of Injury , 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Emily H. Wilson M. D.

(Address) Baltimore - M. D.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Mr. Allen

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

04685

Reg. Diat. No. 21

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Ann Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ann Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Fleet

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lucile Edwards

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
80			..... hrs. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant A. A. Co. Welfare Board

Address 127 Fleet St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 1947 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis Md

18. Funeral director J. B. Johnson

Address Annapolis Md

19. June 10 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 12 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-12- 1947, to 6-6 1947

and that I last saw her alive on 6-6- 1947

Immediate cause of death	DURATION
Carcinoma of uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. T. Allen M. D.

M. D. or other

Address 17 Conrad St. Date signed 6-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 04686 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Fowler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 18 - 47

8. AGE: Years | Months | Days | If less than one day: hrs. 35 min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: David Lee Fowler

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Gertrude Roach

15. Birthplace: Maryland

16. Informant: David Lee Fowler

Address: Weems Creek West Annapolis

17. (Burial, cremation, or removal. Which?) Burial Date thereof June 19 47 (month) (day) (year)

Cemetery or crematory: Cedar Point

Location: Annapolis Md

16. Funeral director: B. F. Hopkins & Son

Address: Annapolis Md

19. June 19 19 47 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 19 47, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 19 47, to June 18 19 47

and that I last saw him alive on June 18 19 47

Immediate cause of death	DURATION
Premature Birth	
Cause Unknown	5 Hrs
Due to (5½ minutes)	
Due to Cause Unknown.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gilbert H. Anderson M.D.
M. D. or other

Address: Annapolis Md Date signed 6/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04687

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore   164a OB

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15   9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 55 East Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Kentucky   County
City or town Owensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 East 5th Street
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3. (a) FULL NAME FREY, Robert Edward

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) April 5, 1927

8. AGE: Years 20 Months 2 Days 24 If less than one day ... hrs. ... min.

9. Birthplace Owensboro, Kentucky (Town, county, and state)
10. Usual occupation U.S. Marine Corps
11. Industry or business

FATHER
12. Name William C. Frey
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Medical Dept. US Naval Station
Address Annapolis, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 2, 1947 (month) (day) (year)
Cemetery or crematory
Location Owensboro, Kentucky

18. Funeral director Ben L. Hopping and Son
Address 170-172 West St, Annapolis, Maryland

July 2 1947 (Date rec'd by registrar)   Wm. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH probably June 28 1947, at about 3 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination 19
~~that I last saw h— alive on~~ June 30 1947

Immediate cause of death	DURATION
Pending result	
Due to: of autopsy	
Due to: and Chemical	
Other conditions: reports - all negative	(8/20/47 abc)

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide (8/20/47 abc) Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Hanging   Injured at work?

23. SIGNATURE John M. Claffy   Deputy Medical Examiner (M. D. or other)
Address Annapolis Md   Date signed 7/2/47

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

183

Registered No.

Bc

04688

1. PLACE OF DEATH: A.A.
(a) ~~Baltimore City, Maryland~~ Bodkin Creek
(b) Street address Pasadena, P.O.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Jackson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Franklin Gallion
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 18, 1905
8. AGE: Years 42 Months Days If less than one day hr. min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Richard Gallion
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Nora Knickemaw
15. Birthplace Maryland

16 (a) Informant Henry Gallion
(b) Address 1812 Jackson St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd
18 (a) Funeral director John F. Denny Inc
(b) Address 714 Light St.
19 (a) June 17-47 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16th 1947, at 1:15 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h/im alive on 19

Immediate cause of death Accidental Drowning — Duration Sudden
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6/16/47 at 1:15 A.M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Gustave H. Faubert [illegible] acting medical examiner M.D.
Address Glen Burnie Md. Date signed 6/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04689 P

CERTIFICATE OF DEATH

Reg. Dist. No. 23-

1. PLACE OF DEATH:
County: Anne Arundel Co
City or town: Linthicum Heights (108 Catalpa Rd.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 1910 -
Hospital, Institution, or street address where death occurred: NW
How long in hospital or institution? Nnd

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel Co
City or town: 108 Catalpa Road.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: — Linthicum Heights.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Myrta Castle Garwood. -

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White.	Married

6.(b) Name of husband or wife: Charles B. Garwood.
6.(c) If alive, give age: 77 years
7. Birth date of deceased (mo., day, yr.): Oct. 2, 1870 -

8. AGE: Years	Months	Days	If less than one day
76	8		— hrs. — min.

9. Birthplace: Melville, New Jersey.
(Town, county, and state)
10. Usual occupation: Housewife -
11. Industry or business: at home -

FATHER
12. Name: ~~Peter~~ Charles Worth.
13. Birthplace: New Jersey -

MOTHER
14. Maiden name: Rachael Woolford.
15. Birthplace: New Jersey.

16. Informant: Charles B. Garwood.
Address: Linthicum Hts. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/4/47 (month) (day) (year)
Cemetery or crematory: Mt. Pleasant Cem.
Location: Millville, N. J.

18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md.

19. 6/3/47 (Date rec'd by registrar) H. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 1947, at 12 30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to June 2 1947
and that I last saw h. alive on June 1, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days.
Due to: Cardio-Vascular Disease	5 years
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James S. Bellingsley M.D.
M. D. or other
Address: Glen Burnie, Md Date signed: June 2, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46e

CERTIFICATE OF DEATH

Reg. Dist. No. 04620

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 198 Prince Geo

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Virginia Basil Giles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Capt Donald T. Giles Jr

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Sept 7 — 1897

8. AGE:

Years	Months	Days	If less than one day
49	9	10	...hrs. ...min.

9. Birthplace annapolis md (Town, county, and state)

10. Usual occupation nurse wife

11. Industry or business

FATHER

12. Name John Basil

13. Birthplace maryland

MOTHER

14. Maiden name Laura A Sammons

15. Birthplace Maryland

16. Informant Capt Donald T. Giles Jr.

Address 198 Prince Geo St Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 47 (month) (day) (year)

Cemetery or crematory Vaul cemetery

Location annapolis md

18. Funeral director B. T. Hopkins & Son

Address annapolis Maryland

19. June 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947 at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1946 to June 17 1947 and that I last saw h.e alive on June 17 1947

Immediate cause of death	DURATION
Acute Dilatation & Heart.	10 hours
Due to Resection partial Transverse Colon	
Due to Intestinal obstruction	1 day
Other conditions Hypertension	unknown

(Include pregnancy within 3 months of death)

Major findings of operations Annular Carcinoma Sigmoid Flexure Colon Date of op. June 9 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Basil M. D. or other

Address Annapolis md Date signed 6-18-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 04691

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Years
Hospital, institution, or street address where death occurred:
88 College Creek Terrace
How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 88 College Creek Terrace
(If rural, give LOCATION)
2.(a) If veleran, name war

3.(a) FULL NAME: Elizabeth Hall

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Febuary 12, 1898

8. AGE: Years	Months	Days	If less than one day
49	4	13	..... hrs. ..... min.

9. Birthplace: Lothian Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: John Hall
13. Birthplace: Lothian Md.

MOTHER
14. Maiden name: Ella Jones
15. Birthplace: Lothian Md.

16. Informant: Matilda Hall
Address: 88 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6- 27- 1947 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery
Location: Spa Road--Smithville Street

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. June 27 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25, 1947, at 1 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.. alive on June 25, 1947 19.....

Immediate cause of death	DURATION
Coronary Failure	1 day
Due to: Hypertension Cardio - Vascular Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: T. G. Simmons M. D. or other
Address: 40 Northwest Street Date signed 6/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04692

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: 2a. Co.

City or town: Grasonville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

STANLEY HANDY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mabel Handy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
42	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal—Which?) Date thereof: June 28-47 (month) (day) (year)

Cemetery or crematory: Bohemia M.E. Church

Location: Grasonville, Maryland

18. Funeral director: John L. Williams

Address: Easton, Maryland

19. 6/27 1947 (Date rec'd by registrar) T. H. Merrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1947 at 9:30A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 21 1947 to June 26 1947 and that I last saw him alive on June 26 1947

Immediate cause of death	DURATION
Status Epilepticus	24 hours
Due to: C. N. S. Lues	
Due to:	
Other conditions: General Paresis	Known to us since June 21, 1947

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a.

CERTIFICATE OF DEATH

Reg. No. 04693 Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Maryland

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1143 Argyle Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alexander Haynie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Louise Haynie

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): unknown to us

8. AGE: Years	Months	Days	If less than one day
75	?	?	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Cement plasterer

11. Industry or business:

FATHER
12. Name: Baldwin
13. Birthplace: ?

MOTHER
14. Maiden name: Margret
15. Birthplace: ?

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-9-1947 (month) (day) (year)

Cemetery or crematory: Mt Zion Cemetery

Location: Baltimore Md

18. Funeral director: Mrs Kate R. Williams

Address: 322 N Schroeder Street

19. 6-7 47 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 19 47 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 47, to June 5 19 47 and that I last saw him alive on June 5 19 47

Immediate cause of death: Cerebral Hemorrhage — DURATION: one day

Due to: General Arteriosclerosis — known to us since May 19,47

Due to:

Other conditions: Psychosis with General Arteriosclerosis — known to us since May 19, 1947
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04694

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Edgewater P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Robert Howard

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COL.	Widowed

6.(b) Name of husband or wife: Rose Howard
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:

Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm, Tobacco
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Daniel Howard
Address: Edgewater P.O. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30. 1947 (month) (day) (year)
Cemetery or crematory: Hazel Star Mem
Location: West River Md
18. Funeral director: E.A. Hardesty & Son
Address: Galesville Md.
19. June 30 1947 (Date rec'd by registrar) Edward Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1947, at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-5-45 1945, to 6-28-47 1947
and that I last saw him alive on 6-17 1947

Immediate Cause of death	DURATION
Congestive Failure	
Due to: Heart failure (Probable Luetic base) [7/20/47 also]	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. T. Collins M. D. or other
Address: 17 Edgewater Date signed: 6-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04695

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH

County: Anne Arundel

City or town: Crownsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 Days

Hospital, institution, or street address where death occurred: State Hospital Crownsville Md.

How long in hospital or institution? since May 6th 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Churchton Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. /

(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME William Howard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	married

6.(b) Name of husband or wife: Mrs. Mary Howard

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 5th 1878

8. AGE: Years	Months	Days	If less than one day
69	2	10	? hrs. ? min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: carpenter

11. Industry or business: ?

FATHER

12. Name: Jim Howard

13. Birthplace: Maryland

MOTHER

14. Maiden name: Rachel Howard nee Blunt

15. Birthplace: Maryland

16. Informant: wife and admitting papers. Address: wife; Rachel Howard, Churchton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18 1947 (month) (day) (year)

Cemetery or crematory: Franklin Cemetery

Location: Beale Md.

18. Funeral director: J. B. Johnson

Address: Annapolis Md

19. June 18 1947 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15th 1947, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6th 1947, to June 15 1947

and that I last saw h.e. alive on June 15th 1947

Immediate cause of death: Status epilepticus

Due to: general paresis of the central nervous system.

Due to: /

Other conditions: /

(Include pregnancy within 3 months of death)

DURATION: 43 hours

Major findings of operations: none

Date of op.: ?

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of: no

Where did injury occur? none (City or town) none (County) none (State)

Injured at home, farm, industry, public place (where?): none

Means of injury: none Injured at work? no

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04696

97

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 6 months, 18 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 5 years, 6 months, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

FANNIE - JACKSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
75 ?	?	?	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Taylor Lawes
13. Birthplace: Virginia

MOTHER
14. Maiden name: Bella Lawes
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-30-47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Dept of Hospt

Address: Crownsville Md

19. 6/30/47 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 19 47 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 19 47, to June 20 19 47

and that I last saw her alive on June 20 19 47

Immediate cause of death: Generalized and cerebral arteriosclerosis — DURATION: Known to us since Dec. 2, 1941

Due to:

Due to:

Other conditions: Senile Psychosis — Known to us since December 2, 1941
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Mayerstein M.D.
M. D. or other

Address: Date signed

M

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VS AR5 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

04697 C

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Maryland
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1106 Gilmer
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Ida James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	unknown to us

6.(b) Name of husband or wife: ?
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
about 69	?	?	..... hrs. ..... min.

9. Birthplace: unknown to us (Town, county, and state)
10. Usual occupation: ?
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. B (Burial, cremation, or removal. Which?) Date thereof 6-6-47 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto. City
18. Funeral director: Samuel W. Sullivan Jr.
Address: 104 N. Arlington Ave
19. 6/6 1947 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 19 47 at 4:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 47 to June 5 47
and that I last saw her alive on June 5 19 47
Immediate cause of death: General Paresis — known to us since May 17, 1947 — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jack Morgenstern M. D. M. D. or other
Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04698 P

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Fort Smallwood, P. O. Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Same County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lemuel Flavius Jenkins.

3.(b) Social Security Number None

4. Sex M.
5. Color or race W.
6.(a) Single, married, widowed, or divorced Married.
6.(b) Name of husband or wife Anna Hancock
6.(c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) March 4 - 1879

8. AGE:

Years	Months	Days	If less than one day
68	3	9	hrs. min.

9. Birthplace Fort Smallwood, P. O. Pasadena, Md
(Town, county, and state)
10. Usual occupation Caretaker of Fort Smallwood
11. Industry or business Farmer

FATHER
12. Name Lemuel F. Jenkins.
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden name Cassie Hancock.
15. Birthplace A. A. County, Md.

16. Informant Mrs. L. F. Jenkins (wife)
Address P. O. Pasadena, Md.

17. Burial Date thereof 6/15/47
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Magothy Church Cem
Location Mountain Rd AACo
18. Funeral director John F. Fleury Inc
Address 745 Light St.
19. 6-16 1947 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at 5 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19
and that I last saw h— alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Pauk... acting Medical Examiner M. D. or other
5 First Ave A. E.
Address Glen Burnie, Md. Date signed 6/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04699 Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10years

Hospital, Institution, or street address where death occurred:
90 Calvert St.

How long in hospital or Institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 90 Calvert St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Jennings

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: **** years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
61				

9. Birthplace: Anne Arundel Co. Nr Annapolis Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: None

FATHER
12. Name: Peter Jennings
13. Birthplace: Anne Arundel Co. Nr Annapolis Md.

MOTHER
14. Maiden name: Elnora Queen
15. Birthplace: Unknown

16. Informant: Mrs Estelle Stanton
Address: 90 Calvert St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 24, 1947 (month) (day) (year)

Cemetery or crematory: ~~Brewer Hill Cemetery~~ Brewer Hill

Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. June 24 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1947 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1947, to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac Fracture	1 day
Due to: Hypertensive Cardio-Vascular Disease	1
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. W. Johnson M. D. M. D. or other

Address: 40 Northwest Street Date signed 6/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

047[illegible]

Reg. Dist. No. 29

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
(Hospital, institution, or street address where death occurred:)
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 1, Box #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Irene Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 19, 1921

8. AGE: 25 Years | 7 Months | 1 Days | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: George Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma Fortune
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23 47 (month) (day) (year)
Cemetery or crematory: Quantico
Location: Quantico Md.

18. Funeral director: James F. Stewart
Address: Salisbury Md.

19. 6/20. 47 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 19 47 at 8:10A. M

21. I CERTIFY that death occurred on the date above stated; that I last attended deceased from June 16 47 to June 20 47 and that I last saw her alive on June 16 19 47

Immediate cause of death: Lobar Pneumonia
Known to us since June 16, 1947

Due to:

Due to:

Other conditions: Epilepsy with Psychosis
Epileptic Deterioration Known to us since June 20, 1946
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Augenstein M. D.
M. D. or other
Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Hooker.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46b

04701

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Waterbury (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME: Moses Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Laura Johnson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): M May 9, 1887

8. AGE: Years	Months	Days	If less than one day
60	2I	2I	... hrs. ... min.

9. Birthplace: A.A.Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Moses Johnson
13. Birthplace: A.A.Co.Md.

MOTHER
14. Maiden name: Lucy Wilson
15. Birthplace: A.A.CO. Md.

16. Informant: Laura Johnson
Address: Waterbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2, 1947 (month) (day) (year)
Cemetery or crematory: Cross Roads
Location: Waterbury, Md.,.

18. Funeral director: J.B.Johnson
Address: Annapolis, ,Md.

19. July 2, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 JUNE July 1947, at 3:00 P. M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 1 June 1947, to 29 July June 1947, and that I last saw h. alive on 29 July June 1947.

Immediate cause of death	DURATION
Coronary occlusion	15 min.
Due to arteriosclerosis	
Due to	
Other conditions Carcinoma of stomach	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: no operations Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Donald H. Hooker, M.D. M. D. or other
Address: 53 Cornhill St. Annapolis Date signed: July 4, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04702

[redacted]

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 5 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 11 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

Street No. 824 J Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Joe P. Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
65	?	?	hrs. min.

9. Birthplace: Unknown to us
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 21, 1947
(month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Annapolis Road

18. Funeral director: Mrs. Robert Elliot & Daughter
Address: 1129 N. Caroline Street

19. 7-11-47
(Date rec'd by registrar)

H. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18, 1947, at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13, 1946, to June 18, 1947, and that I last saw him alive on June 18, 1947.

Immediate cause of death	DURATION
General Paresis	Known to us since July 13, 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: ------

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jack Mayerson M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 6/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04703

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution? dead a arrival

2. USUAL RESIDENCE (HOME) OF DECEASED: (If newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Sunset Beach (If outside city or town limits, write RURAL and give nearest town)
Street No. Pasadena P.O., Md. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Hobart Keech, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Blanche V. Keech
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1869.

8. AGE: Years 77 | Months 5 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Baltimore City, Maryland (town, county, and state)
10. Usual occupation: Physician
11. Industry or business: Medical Practioner

FATHER
12. Name: Henry Hobart Keech
13. Birthplace:

MOTHER
14. Maiden name: Hattie B. Peddicord
15. Birthplace: Fallston Md.

16. Informant: Mrs. H. H. Keech
Address: Pasadena P.O., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/9/47 (month) (day) (year)
Cemetery or crematory: Greenmount Cem.
Location: Baltimore, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. June 7 1947 A. N. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1947, at 9.05 p. M

21. I CERTIFY that death occurred on the date above stated: ~~Attended deceased from~~ Post-mortem Examination = June 5 1947.

	DURATION
Immediate cause of death: Coronary embolism	Sudden
Due to: Coronary sclerosis.	Indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Cassy, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 6-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

047014

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 910 Frances Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 910 Frances Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John William King

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. King
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 6th 1868

8. AGE:

Years	Months	Days	If less than one day
79	6	14	hrs. min.

9. Birthplace: Millersville Md.
(Town, county, and state)
10. Usual occupation: Fireman & Engineer
11. Industry or business
FATHER 12. Name: John King
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Bryan
15. Birthplace: Maryland
16. Informant: Mary E. King
Address: 910 Frances St. Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17th 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: 147 Duke of Gloucester St. Annapolis Md.
19. June 16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 1947 at 5 00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 14 1947 and that I last saw h... alive on June 14 1947
Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 days
Due to: Arteriosclerosis
Due to: Cardio-Vascular disease — DURATION: 2 yrs.
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis Md. Date signed 6/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of age is shown on

04705

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

FILE No. G 110 JUN 23 1947

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:

County a a

City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or rural address where death occurred:

Lothian. md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Kirchner Sr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widow

6.(b) Name of husband or wife Maggie Kirchner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1858

8. AGE: Years	Months	Days	If less than one day
88	89	9	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name William Kirchner

13. Birthplace Germany

MOTHER

14. Maiden name Margaret Knopp

15. Birthplace Germany

16. Informant Mrs Edna Moreland

Address Lothian, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18/47 (month) (day) (year)

Cemetery or crematory Galesville M.E.

Location Galesville. Md

18. Funeral director B L Hopkins & Son

Address Annapolis. Md

19. 6/17 1947 (Date rec'd by registrar) M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947 to June 16 1947 and that I last saw him alive on June 16 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis - Cardiac disease	2 yrs.
Diher condiitions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert H. Culbertson M.D. M. D. or other

Address Annapolis, Md Date signed 6-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04706

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

1601 West St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1601 West St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME Albert Guy Layman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Violet B. Layman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17th 1900

8. AGE: Years 46 Months 6 Days 12 If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Employe U.S. Naval Experimental Station

11. Industry or business:

FATHER 12. Name: John A. Layman

FATHER 13. Birthplace: Pipe Creek Md.

MOTHER 14. Maiden name: Rena Stubblefield

MOTHER 15. Birthplace: A A Co Md.

16. Informant: Mrs A. Guy Layman

Address: 1601 West St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1st 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John W. Taylor Son

Address: Annapolis Md.

19. July 1 47 (Date rec'd by registrar) Wm Darnall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29, 1947 at 2 15 A M

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination

~~suicide, homicide, or accident~~ June 29, 1947

	DURATION
Immediate cause of death	
Coronary Thrombosis	sudden
Due to	
Coronary Sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner M. D. or other

Address: Annapolis, Md Date signed 6/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (9-45) 15M

STATE OF MARYLAND—CERTIFICATE OF DEATH

480 04707

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 25

Village or City Brooklyn No. 4102 Ritchie Highway St., or Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where deeth occurred ..... yrs. 2 mos. ..... ds. How long in U.S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Margaret M. Lettau If U. S. Veteran, specify WAR .....

(a) Residence: No. 4102 Ritchie Highway St., or Ward. .....

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest B. Lettau

6. DATE OF BIRTH (month, day, and year) 11/6/1886

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	7	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House Wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. .....

10. Date deceased last worked at this occupation (month end yeer) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) Baltimore (State or country)

FATHER

13. NAME Michael Bahnline

14. BIRTHPLACE (city or town) Baltemore (State or country)

MOTHER

15. MAIDEN NAME Sarah .

16. BIRTHPLACE (city or town) Baltimore (State or country)

17. INFORMANT Mr C B Lettau (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Cedar Hill Date 6/12/47 19....

19. UNDERTAKER John J. Bohen Sons (Address) 1317 Light St.

20. FILED June 11, 1947 A. W. Hebert Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June (Month) 8 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 5 1947, to June 8, 1947

I last saw h.. elive on June 8, 1947; deeth is said to have occurred on the date stated above, at 3 30 m.

The PRINCIPAL CAUSE OF DEATH and releted causes of Importance were es follows:

	Date of onset
Carcinoma of the cervix	
Dther Contributory Causes of importance:	

Neme of operation ..... Dete of .....

Whet test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Dete of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether Injury occurred In INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of Injury .....

Neture of injury .....

24. Was diseese or injury In any way related to occupation of deceased? .....

If so, specify .....

(Signed) Samuel Rushin M. D.

(Address) 205 Balaberse ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Mr. Clemens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

04708

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Ft Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Francis Manns

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	widow

6.(b) Name of husband or wife Charles C. Manns
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			..... hrs. ..... min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Joshua Henson
13. Birthplace A. A. Co.
MOTHER 14. Maiden name Hannah Henson
15. Birthplace A. A. Co
16. Informant William Henson
Address 890 Linden Ave. Baltimore, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15 1947 (month) (day) (year)
Cemetery or crematory Townneck Cem.
Location Severna Park Md.
18. Funeral director J. B. Johnson
Address Annapolis Md
19. June 15 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947, at 7:06 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to 6/10/47 19...
and that I last saw h.er alive on June 10, 1947

Immediate cause of death	DURATION
Cerebral Hemorrage	Immediate
Due to Cardio-Renal disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Gilbert L. Anderson M.D. M. D. or other
Address Annapolis Md Date signed 6/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 04749 26

1. PLACE OF DEATH:

County A. A. Co.

City or town Deale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Deale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Robert Alphonzo Marshall

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male 75	White	(1) married

6.(b) Name of husband or wife Rose Ella

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct 28 1871

8. AGE: Years	Months	Days	If less than one day
75	7	11	....hrs. ....min.

9. Birthplace Deale, A. A. Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Oysterman

FATHER 12. Name Wm. J. Marshall

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Rachael J. Rowles

MOTHER 15. Birthplace Md.

16. Informant Rose Ella Marshall

Address Deale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/11/47 (month) (day) (year)

Cemetery or crematory St. James

Location Tracys Md.

18. Funeral director T. A. Hardesty & Son

Address Deale Md

19. June 10 1947 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 28 1947, to June 9 1947

and that I last saw h... alive on June 9 1947.

Immediate cause of death	DURATION
Cerebral hemmorhage	
Due to Hypertension	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson, M.D.
M. D. or other

Address Lothian Md. Date signed 6/10/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04710

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 207 - 4th St. S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Martin.

3.(b) Social Security Number 215-01-2600

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian Martin
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 18. 1882

8. AGE:

Years	Months	Days	If less than one day
65	0	16	hrs. min.

9. Birthplace: Glen Burnie, Anne Arundel Co., Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Asst. Coast Guard Sta. ret.

FATHER
12. Name: Richard Martin
13. Birthplace: Anne Arundel Co., Md.

MOTHER
14. Maiden name: Dallas Gaither
15. Birthplace: Harwis Anne Arundel Co., Md

16. Informant: Mrs. Lillian Martin
Address: Glen Burnie, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1947 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. June 4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1947, at 10 00 A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination to ~~and that I last saw him alive on~~ June 3 1947

Immediate cause of death	DURATION
Coronary embolism	sudden
Due to	
Coronary Sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John M. Cluff M.D., Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md Date signed 6/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

04711

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:
16 Murray Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Murray Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Samuel Aaron Martin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Eleanor Martin

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1910

8. AGE: Years	Months	Days	If less than one day
36	10	13	hrs. min.

9. Birthplace: Jena, Louisiana
(Town, county, and state)

10. Usual occupation: Instructor

11. Industry or business: U.S.N.A.

FATHER 12. Name: Earie Lunford Martin

FATHER 13. Birthplace: Louisiana

MOTHER 14. Maiden name: Mary May Shurtleff

MOTHER 15. Birthplace: Arkansas

16. Informant: Mrs. Eleanor Martin

Address: 16 Murray Ave.

17. Burial Ware Date thereof June 26-1947
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory: Ware Church

Location: Gloucester Va.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md

19. June 24 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 19 47 at 3 30 A.M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Rutchings, M.D.
M. D. or other acting M. E.

Address: Annapolis, Md. Date signed: June 23, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-25-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1242

CERTIFICATE OF DEATH

8

04712

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hosp.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Bay Ridge (If outside city or town limits, write RURAL and give nearest town)
Street No.: 96 River Drive (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: HENRY JACOB NEEBE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Virginia Neebe
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 29, 1879

8. AGE: Years	Months	Days	If less than one day
68	3	6	..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Sales Mgr.
11. Industry or business: Maryland Biscuit Co.
FATHER 12. Name: Conrad Neebe
13. Birthplace: Germany
MOTHER 14. Maiden name: Amelia Hackett
15. Birthplace: Philadelphia
16. Informant: Mrs. Virginia Neebe
Address: 96 River Drive, Bay Ridge Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/7/47 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 6/5 19 XD A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 19 47 at 6 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 47 to June 5 19 47
and that I last saw h.. alive on June 5 19 47

Immediate cause of death	DURATION
Carcinoma of Liver	1 year.
Due to	
Due to	
Other conditions Caseous Calcareous Gallstones	Unknown.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: George C. Basil M. D. or other
Address: Annapolis Md. Date signed 6-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Reg. Dist. No. 04713

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 12 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 2 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 826 N. Vincent
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Nelson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Unknown Eva

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown April 3 1903

8. AGE: Years	Months	Days	If less than one day
43	?	?	hrs. min.

9. Birthplace: ~~Virginia~~ Balto., Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: ? Joseph Nelson

FATHER — 13. Birthplace: ? Md.

MOTHER — 14. Maiden name: ? Elizabeth ?

MOTHER — 15. Birthplace: ? Md.

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/18/1947 (month) (day) (year)

Cemetery or crematory: Mount Auburn

Location:

18. Funeral director: Katie K. Willson

Address: 322 N. Belnord st

19. June 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1947 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947 to June 12 1947 and that I last saw h... alive on June 12 1947

Immediate cause of death	DURATION
General Paresis of the C.N.S.	
Due to: Known to us since March 1, 1947	
Due to:	
Other conditions: General Paresis of the C.N.S. (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M. D.
M. D. or other

Address: Date signed:

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04714

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County A. A.
City or town Sudley (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME raintree
Alphonso F Nutwell

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Julia Adella Nutwell
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 23 1880

8. AGE: Years	Months	Days	If less than one day
67	2	17	hrs. min.

9. Birthplace Lothian, A.A. Co. Md. (Town, county, and state)
10. Usual occupation Farmer and veterinarian
11. Industry or business Farming
FATHER 12. Name Edward Nutwell
13. Birthplace Lothian Md.
MOTHER 14. Maiden name Mary Jane Minnick
15. Birthplace Baltimore City Md
16. Informant Julia A. Nutwell
Address Sudley Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/21/47 (month) (day) (year)
Cemetery or crematory Mt Zion
Location Lothian
18. Funeral director T. D. Hardesty & Son
Address Galesville Md.
19. June 20 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 47, at 7:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 47, to June 19 47 and that I last saw h. liv. alive on June 19 19 47

Immediate cause of death	DURATION
Coronary occlusion	
Due to Hypertensive Cardio Vascular disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E Pinkett M. D. or other
Address Easton, Maryland Date signed 6/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Mrs Jenny B Smith
Leesville
Mrs Ella Liggett
Mrs Fannie Tuckers
Davidsville

Let 3 P.M. Called

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87C

CERTIFICATE OF DEATH

Reg. Dist. No. 04715 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County A. A Co.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
10 Madison Street
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A A Co.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 Madison Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ann Parkinson

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: George Parkinson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 3/3/1870

8. AGE: Years 77 | Months 3 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Mrs. Sidney Lyons
Address Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/17/47 (month) (day) (year)
Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis Maryland

18. Funeral director John M. Taylor Son
Address Annapolis Maryland

19. June 16 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947 at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1940 to June 13 1947 and that I last saw h.r alive on June 13 1947

Immediate cause of death 4 Paralysis Agitans — DURATION: Several years

Due to

Due to

Other conditions Cataract Jelenus — DURATION: Unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Boyd M. D. or other
Address Annapolis Md Date signed 6-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

D4716

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: P. G.

City or town: Chesapeake Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Edgewater Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: Lucas Point Shores (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Fulton Plummer

3.(b) Social Security Number: 577-10-8137

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie R. Plummer

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1905.

8. AGE:

Years	Months	Days	If less than one day
41	11	12	... hrs. ... min.

9. Birthplace: Lower Marlboro Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Clarence Plummer

FATHER — 13. Birthplace: Charleyville, Md.

MOTHER — 14. Maiden name: Gertrude Veazey

MOTHER — 15. Birthplace: Churchville Md.

16. Informant: Spouse

Address: Lower Marlboro Md.

17. Buried (Burial, cremation, or removal? Which?) Date thereof: June 25, 47 (month) (day) (year)

Cemetery or crematory: Largents Chapel Cem.

Location: Lower Marlboro, Md

18. Funeral director: W. N. Hutchins

Address: Owings, Md

19. June 15 19 47 (Date rec'd by registrar) Grace L. Hutchins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22, 1947 at 5:40 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to June 22, 1947 and that I last saw h... alive on June 22, 1947

Immediate cause of death	DURATION
Heart Failure	3 days
Respiratory paralysis	
Due to: Apoplexy	2 years
Due to: Hypertension	30+ yrs
Chronic Nephritis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. M. D. or other

Address: Chesapeake Md. Date signed: 6/23/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Sorry, I over-
looked [illegible] when
I sent the other
form in. — G. Hutchins

04717

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 18

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years, 7 months, 2 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 21years, 7 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 914 Russell
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rosie Pryor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: James Pryor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
73	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-30-47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md.

18. Funeral director: Supt. J Hoskth

Address: Crabsburg Md.

19. 6/30.47 (Date rec'd by registrar) 19 E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1947, at 11:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1925 to June 18 1947

and that I last saw her alive on June 18 1947

Immediate cause of death	DURATION
Myodegeneratio cordis	Known to us since
	March 12, 1947
Due to:	
Due to:	
Other conditions: Involutional Psychosis	Known to us since
(Include pregnancy within 3 months of death)	November 16, 1925

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Brazenton M.D. M. D. or other

Address: Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04718

Reg. Dist. No.

P

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: a. a.

City or town: Wardour

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 215 Westwood Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: a. a.

City or town: Wardour

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 215 Westwood Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine Ann Remley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or ~~divorced~~
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Edwin Remley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10th 1875

8. AGE: Years 71 | Months 10 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Balto. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER 12. Name: Benjamin F. Auld

13. Birthplace: Balto. Md.

MOTHER 14. Maiden name: Catherine A. W. Clark

15. Birthplace: Balto. Md.

16. Informant: Mrs Melvin M. Gessell

Address: Cedarhurst Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 6/5/47 (month) (day) (year)

Cemetery or ~~crematory~~: Mt. Olivet

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. June 4 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

JS

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 1947 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1947 to June 2 1947 and that I last saw h[illegible] alive on June 1 1947

Immediate cause of death	DURATION
Myocarditis with Myocardial Insufficiency	unknown
Due to: Arteriosclerosis	unk
Due to:	
Other conditions Chr. Rheumatoid Arthritis	6 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Grace C Boeil M. D. or other

Address: annapolis md Date signed 6-2-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

04713

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1303 West Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1303 West St.
(If rural, give LOCATION)
2.(a) If votoran, name war

3.(a) FULL NAME William T. Russell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widower

6.(b) Name of husband or wife Henrietta Russell
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20th 1854

8. AGE: Years 92 | Months 6 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Ret Police of Balto City

11. Industry or business

FATHER 12. Name John W. Russell
13. Birthplace Delaware

MOTHER 14. Maiden name Ann Whorton
15. Birthplace Md

16. Informant Chas M. Russell
Address 1303 West St. Annapolis Md.

17. Burial Date thereof June 17th 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore Cemetery
Location Baltimore Md.

18. Funeral director John M. Jay Est. Son
Address Annapolis Md.

19. June 15, 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1947 to June 13 1947 and that I last saw h... alive on June 13, 1947

Immediate cause of death	DURATION
Acute Dilatation of the Heart	2 Hours
Due to	
Due to	
Other conditions Carbo-Renal Disease	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M.D.
M. D. or other
Address Annapolis Md. Date signed 6/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 04720

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, institution, or street address where death occurred:
Annapolis Emergency Hospital
How long in hospital or institution? dead on arrivel

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For stillborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Belvedere Beach
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Ruth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife: Wm Ruth
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Apr 19, 1886

8. AGE: Years	Months	Days	If less than one day
61			..... hrs. ..... min.

9. Birthplace: Russia
(Town, county, and state)
10. Usual occupation:
11. Industry or business
FATHER 12. Name: Jacob Crauchdes
13. Birthplace: Russia
MOTHER 14. Maiden name: Unknown
15. Birthplace: Russia
16. Informant: Mrs Malvina Bettiens
Address: 2900 Rosalie Ave
17. Burial (Burial, cremation, or removal, which?) Date thereof July 2, 47 (month) (day) (year)
Cemetery or crematory: Annapolis
Location: Landon Lane
18. Funeral director: L. Heckman & Son
Address: 6067 Harford Rd
19. 7/2 19 47 H. A. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 19 47 at 8 40 P M
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination June 29, 19 47

Immediate cause of death	DURATION
Acute dilatation of Heart	sudden
Due to: Arteriosclerosis	
Due to: Diabetes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 6/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04721

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Bay Ridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4303 Wentworth Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: David S. Rutt

3.(b) Social Security Number: 213-05-0337

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 5, 1916
8. AGE: Years: 31 Months: 1 Days: 21 If less than one day: hrs. min.
9. Birthplace: Bonneville, Ohio
(Town, county, and state)
10. Usual occupation: Clerical
11. Industry or business:

FATHER
12. Name: Eli J. Rutt
13. Birthplace: Goreland, Nebraska

MOTHER
14. Maiden name: Emma Smucker
15. Birthplace: West Liberty, Ohio

16. Informant: Eli J. Smucker
Address: 4303 Wentworth Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-1-47 (month) (day) (year)
Cemetery or crematory: Loraine Cemetery
Location: Woodlawn, Md.

18. Funeral director: Wm. J. Lechner
Address: Baltimore, Md.

19. July 1, 1947 (Date rec'd by registrar) Wm. Branch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1947 at 6 15 P.M.

21. I CERTIFY that death occurred on the date above stated: to ~~the best of my knowledge~~ Postmortem Examination ~~I last attended deceased~~ June 28, 1947

Immediate cause of death	DURATION
Due to: Coronary Embolism	
Due to: Coronary Sclerosis	
Other conditions: Was working in shallow water. (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 6/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

STATE OF MARYLAND—CERTIFICATE OF DEATH 04722

1310

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 20

Village or City Severnville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Elizabeth Baker Shubert If U. S. Veteran, specify WAR

(a) Residence: No. West River, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	white	widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Shubert-

6. DATE OF BIRTH (month, day, and year) April 28, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	1	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none-

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

FATHER

13. NAME Jeremiah Baker

14. BIRTHPLACE (city or town) Talbot Co. Md. (State or country)

MOTHER

15. MAIDEN NAME Alvina Collison

16. BIRTHPLACE (city or town) Talbot Co. Md. (State or country)

17. INFORMANT Jenge Shubert- (Address) West River a a Co Md

18. BURIAL, CREMATION, OR REMOVAL Place Hope Chapel Date June 19th, 1947

19. UNDERTAKER Robert T. Smith (Address) Annapolis Md.

20. FILED June 17, 1947 Edward Collison Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June (Month) 16 (Day) 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 11, 1947, to June 16, 1947

I last saw h-r alive on June 16, 1947; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Bilateral pneumonia	
Chronic myocarditis	

Other Contributory Causes of importance:

Chronic nephritis
hypertension
Arteriosclerosis

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Emily H. Wilson M. D.

(Address) Collison, Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

04723

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH

County A A Co

City or town WATER-OAK Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A. Co

City or town Water Oak Point

(If outside city or town limits, write RURAL and give nearest town)

Street No. Pasadena Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ANDREW S STENGER SR.

3. (b) Social Security Number

4. Sex MALE

5. Color or race W.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife MARY. STENGER

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH. 19 1868

8. AGE: Years 79 | Months 3 | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace BALTO MD.

(Town, county, and state)

10. Usual occupation RETIRED.

11. Industry or business -

FATHER

12. Name Not Known

13. Birthplace Not Known

MOTHER

14. Maiden name Not Known

15. Birthplace Not Known

16. Informant ANDREW. S STENGER Jr.

Address WATER OAK. POINT. PASADENA MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6-23-47 (month) (day) (year)

Cemetery or crematory HOLY CROSS CEMETERY

Location A A Co

18. Funeral director Bernard E Hanle

Address 121 E West St.

19. June 21 19 47 (Date rec'd by registrar) Edna M. Wheelan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 47, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 19 47, to June 15 19 47 and that I last saw h alive on June 15 19 47

	DURATION
Immediate cause of death Myocardial Insufficiency	
Due to Hypertension 10 yrs.	3 yrs.
Due to	
Other conditions Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leon Pittard M.D. M. D. or other

Address Same as Informant Date signed June 23 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77d

CERTIFICATE OF DEATH

Reg. Diat. No. 04724

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 406 Third
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Telfer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Bertha Telfer
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13th 1905

8. AGE: Years 42 | Months 1 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Tank driver

11. Industry or business American Oil Co.

FATHER 12. Name Daniel Telfer
13. Birthplace Scotland

MOTHER 14. Maiden name Elizabeth Stewart
15. Birthplace Scotland

16. Informant Mrs Bertha Telfer
Address 406 Third St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21st 1947 (month) (day) (year)
Cemetery or crematory Glen Haven Memorial
Location Glen Burnie, Md.

18. Funeral director John M. Taylor Funeral Home
Address Annapolis Md.

19. June 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1947 to June 17 1947 and that I last saw him alive on June 16 1947

Immediate cause of death	DURATION
Carcinoma Larynx.	
Chronic Alcoholism	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Eastport Md Date signed 6/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

117a

04725 A

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Severna Park. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred: at Home
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2122 Chelsea Ter. Baltimore Md
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Johanna Frederika Thies

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Aug 14, 1874 1873

8. AGE: Years	Months	Days	If less than one day
73	10	13	hrs. min.

9. Birthplace: Baltimore. Md.
(Town, county, and state)
10. Usual occupation: At home.
11. Industry or business: —

FATHER
12. Name: Henry Thies.
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Guth.
15. Birthplace: Germany

16. Informant: Mrs Frieda C. Thies.
Address: 3006 St Paul St. Balt. Md.

17. Cremation (Burial, cremation, or removal: which?) Date thereof June 30 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore City.

18. Funeral director: Stewart Mortuary Company
Address: 108 W York - Baltimore Md

19. 6/30 19 47 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1947 at 1 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1947, to June 27 1947
and that I last saw h— alive on June 27 1947

	DURATION
Immediate cause of death: Hemorrhage of the Stomach	10 days
Due to: Ulcer of the Stomach	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: Ulcer of the Stomach
Date of op. 1924
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James S. Billingslea M D
M. D. or other
Address: Glen Burnie Md Date signed: Jun 27, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310 04726

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred:

59 Spa. Road

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 59 Spa road

(If rural, give LOCATION)

2.(a) If veteran, name war: ********

3. (a) FULL NAME: Mollie Savoy Tongue

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: ********

6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): September 1883

8. AGE: Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace: Anne Arundel Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: James Scott

13. Birthplace: Anne Arundel

MOTHER

14. Maiden name: Eliza Duckett

15. Birthplace: Bowie Md.

16. Informant: Mrs Helen Savoy Jones

Address: 59 Spa road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30, 1947 (month) (day) (year)

Cemetery or crematory: St. Anne s Cemetery

Location: Northwest St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. June 30 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1947, at 4.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 5 1946, to June 26 1946

aed that I last saw h... alive on June 24 1947

Immediate cause of death	DURATION
a. Pulmonary Edema	1/2 hr.
Due to Arteriosclerotic Heart Disease	yrs.
Due to Nephritis & hypertension.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. F. Klaxans, M.D. M. D. or other

Address: 31 Entrance Cir. Date signed 6/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04727

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 112 McKendree Ave.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 McKendree Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henry Lracy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Edna M. Lracy
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jany 25 1898

8. AGE: Years 49 Months 4 Days 16 If less than one day ..... hrs. ..... min.

9. Birthplace: Cincinnati Ohio
(Town, county, and state)

10. Usual occupation: War Assets Adm.

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Edna M. Lracy
Address: 112 Mc Kendree Ave Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/15a/47 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Annapolis Md.

18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. June 12 1947
(Date rec'd by registrar)
W. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 19 47 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h... alive on ..... 19 .....

Immediate cause of death	DURATION
Natural Causes	
Due to Coronary Occlusion	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE [signature] Asst. Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 6/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04728

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Martin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Vann B. Wade

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Velma H. Wade

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 17th 1900

8. AGE:

Years	Months	Days	If less than one day
46	8	24	..... hrs. ..... min.

9. Birthplace Bells Tenn. (Town, county, and state)

10. Usual occupation Foreman for Steel Co

11. Industry or business

FATHER 12. Name Vann B. Wade

FATHER 13. Birthplace Oklahoma

MOTHER 14. Maiden name Bertie L. Montague

MOTHER 15. Birthplace Bells Tenn.

16. Informant Mrs Velma H. Wade

Address 3 Martin St. Annapolis Md.

17. Burial Date thereof June 15th 1947 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Sayler Son

Address Annapolis Md

19. June 12 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947, at 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased~~ from ..... 19..., to ..... 19...

and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. Peyton Ritchie, M.D.

M. D. or other

Address Annapolis, Md. acting M.E. Date signed June 10, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

04721

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Elmhurst - P.O. Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Warren

3. (b) Social Security Number: 717-07-6563

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored.	Married.

6.(b) Name of ~~husband or~~ wife: Josie Parker

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): August 27 - 1904

8. AGE: Years	Months	Days	If less than one day
42	11	27	..... hrs. ..... min.

9. Birthplace: Severn, Md.

(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER — 12. Name: John H. Warren

13. Birthplace: Charles County, Md.

MOTHER — 14. Maiden name: Laura Egmon

15. Birthplace: Washington, D. C.

16. Informant: Josie Warren - wife

Address: Severn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 3 1947 (month) (day) (year)

Cemetery or crematory: St. Marks

Location: Severn, Md.

18. Funeral director: Mrs Katie R. Williams

Address: 322 N. Schroder St

19. July 2 1947 (Date rec'd by registrar) A. W. Redwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1947, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19..., to ... 19...

and that I last saw h... alive on — 19...

Immediate cause of death	DURATION
Drowning in a well	Sudden
Due to: Coronary trouble	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 6/30/47

Where did injury occur? Elmhurst (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Well

Means of injury: Drowning Injured at work? at present

23. SIGNATURE: Gustave H. Pauber, M.D. acting Medical Examiner M. D. or other

Address: Odenton, Md. Date signed: 6/30/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106 E

04730

CERTIFICATE OF DEATH

BC Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 7 months, 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Maryland
How long in hospital or institution? 4 years, 7 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2006 Hunter Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: James Washington

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1867

8. AGE	Years	Months	Days	If less than one day
	85	?	?	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborere
11. Industry or business:
FATHER — 12. Name: Unknown
13. Birthplace:
MOTHER — 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/23/47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Asylum Hospital
Address: Crownsville Md
19. 6/23/47 (Date rec'd by registrar) Ethyl Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15, 1947 at 2:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 1942 to June 15 1947
and that I last saw him alive on June 15 1947

Immediate cause of death	Putrid Bronchitis	DURATION: Known to us since May 16, 1947
Due to		
Due to		
Other conditions	Senile Psychosis, paranoid type	Known to us since Nov. 6, 1942

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Mongeuten M.D. M. D. or other
Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04731

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Wild Rose Shores, South River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a day
Hospital, Institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: New Jersey County: Atlantic
City or town: Atlantic City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Atlantic Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Weinberg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aug 12 1891

8. AGE: Years	Months	Days	If less than one day
55	10	20	... hrs. ... min.

9. Birthplace: Phila Pa.
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business
FATHER 12. Name: Morris Weinberg
13. Birthplace: Russia
MOTHER 14. Maiden name: Ida Cohen
15. Birthplace: Russia
16. Informant: J. Meddelman
Address: 312 Atlantic Ave Atlantic City N.J.
17. Burial, cremation, or removal. Which? Removal Date thereof 6-22-47 (month) (day) (year)
Cemetery or crematory
Location: Atlantic City N.J.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. June 22 1947 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1947 at 4:25 P.M.
21. I CERTIFY that death occurred on the date above stated; [redacted]
Post Mortem Examination 19...
and [redacted] June 21, 1947

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to: Coronary sclerosis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 6/22/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04732

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes.
Hospital, institution, or street address where death occurred: Clay Banks
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: A. A.
City or town: Severn.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: New Cut Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry Clyde Wilson
3.(b) Social Security Number:

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 1st 1929
8. AGE: Years 17; Months 9; Days 15; If less than one day ... hrs. ... min.
9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Pipefitters-Helper
11. Industry or business: Byrne Construction.

FATHER
12. Name: Hansel C. Wilson.
13. Birthplace: Pennsylvania.

MOTHER
14. Maiden name: Sadie Best
15. Birthplace: Frederick County. Md.

16. Informant: Mrs. H. C. Wilson (mother)
Address: Severn, Md.

17. Burial — Date thereof: June 19, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. 6/17 1947 — Registrar: M. S. DeAlba
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1947, at 7:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— , to — 19
and that I last saw h... alive on ... 19

Immediate cause of death	DURATION
Accidental Drowning	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of: 6/15/47
Where did injury occur? Clay Banks — A. A. — Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Clay Banks.
Means of injury: Drowning. Injured at work? No

23. SIGNATURE: Gustave H. Fauber(?) M.D.
acting medical examiner — M. D. or other
Address: Glen Burnie Md. Date signed: 6/16/47

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04733

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CERTIFICATE OF DEATH

Reg. Diat. No. 2

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Edgewater Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Outside Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fort Meade Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Raymond C. Wines

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-2-1928

8. AGE: Years: 18 | Months: 11 | Days: 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Co. (Town, county, and state)

10. Usual occupation: General laborer

11. Industry or business

FATHER

12. Name: Elias Clinton Wines

13. Birthplace: Va.

MOTHER

14. Maiden name: Lida Belle Lisby

15. Birthplace: Baltimore, Md.

16. Informant: Earl Leroy Wines

Address: 35 "A" St. Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-26-47 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel, Md.

18. Funeral director: DeWitt Donaldson

Address: Laurel, Maryland

19. June 28 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1947 at 8 45 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~Unattended by me~~ Post mortem Examination

~~and last attended by me on~~ June 26 1947

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 6/25/47

Where did injury occur? Edgewater A.A., Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): South River

Means of injury: drowning Injured at work? no

23. SIGNATURE: John N. Coffey, M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis Md Date signed: 6/27/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

04734 P

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel.
City or town Ferndale.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town ~~Same~~ (If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Lawrence J. Witkowski.

3. (b) Social Security Number 214-03-4725

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife Lillian Dennski
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
55			..... hrs. ..... min.

9. Birthplace Poland. (Town, county, and state)
10. Usual occupation Crane Operator.
11. Industry or business

FATHER
12. Name Steven Witkowski
13. Birthplace Poland.

MOTHER
14. Maiden name Josephine Cikoski
15. Birthplace Poland.

16. Informant Mrs. Frank Witkowski.
Address Ferndale. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26/47 (month) (day) (year)
Cemetery or crematory Holy Rosary
Location Baltimore
18. Funeral director Fred W. Ozazewski
Address 1930 Eastend Ave.

19. June 24 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947 at 11.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	sudden.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Gustave H. Bouchard M.D. M. D. or other
acting medical examiner
Address Glen Burnie, Md Date signed 6/23/47